

THE

MEDICAL JOURNAL OF AUSTRALIA

(With which "The Australasian Medical Gazette," and "The Australian Medical Journal" are incorporated.)

The Journal of the Australian Branches of the British Medical Association.

VOL. II.—5TH YEAR—No. 22.

SYDNEY: SATURDAY, NOVEMBER 30, 1918.

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A MINISTRY OF HEALTH AND A NATIONAL HEALTH SERVICE.¹

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A few words of explanation as to the genesis of this paper may be advisable.

Members may be aware that at the Federal Committee Meeting, August, 1917, the New South Wales representatives presented certain resolutions *re* the nationalization of medical service, the gist of which may be briefly summarized as recognizing the need for such service in certain departments, but otherwise deprecating the disturbance of the ordinary arrangements between patients and their medical attendants. These general principles were referred with some modifications to the Branches, and were adopted at the February meeting of the Federal Medical Committee this year. At the same meeting the New South Wales representatives secured the passage of a resolution asking the Branches to submit proposals for a national medical service involving any necessary degree of nationalization, but not inconsistent with the principles already adopted. At the August meeting it was found that no such proposals had been submitted by any Branch. During the interval, some copies of the pamphlet on a Ministry of Health, published by the British Medical Association in England, has been received here, through the kindness of Dr. H. S. Newland, and as some of the smaller Branches found difficulty in making concrete proposals, owing to lack of information, it was thought advisable to distribute copies of this pamphlet throughout all the Branches. It is hoped that you have all had a copy and have read it and profited by it. Its publication shows that the matter contained in it is being actively debated by the profession in England. A study of its contents gives valuable ideas, and shows a determined and broad-minded effort to thrash out basic principles for a plan by which we may combine our present voluntary and individualistic system, both of private treatment and hospital attendance, with new methods designed for greater efficiency in the maintenance of public health.

But I do not know that it can afford much more help than that to us out here. The historical review is, of course, quite unsuited to us—the local conditions are quite different. On that account I have deemed it better to get right away from its details in this discussion, and find out principles for ourselves which we can use as the foundation for our own constructive work.

The outstanding preliminary difference that I see between English conditions and ours is that, whereas this pamphlet gives a list of bodies concerned with public health whose functions overlap, our public health bodies, when considered from the Australian point of view, are more in the nature of a collection of closed circles or spheres of influence, with too many

interstices between the bodies. For we have not yet attained to a national point of view, as they have in England; we have not even one central body, like either the General Medical Council or the Local Government Board, or any similar administrative department of Government. And the first essential, it seems to me, is for us to endeavour to look at matters from this national point of view, to take all Australia into our view, and all sides of public health, rather than one State or one aspect, and thus begin to think out a national health service.

I have preferred to write under the title "A National Health Service" because to tell the truth, I am rather tired of hearing talk about the "nationalization" of the medical profession. To begin with, it is a contradiction in terms. While we still existed as separate States we nationalized our railways, but no one dreamed of nationalizing railway men. We talk of a national system of education, but never of nationalizing teachers, and, similarly, while it may be quite correct to talk of nationalizing medical service, it is absurd to talk of nationalizing medical men or the medical profession. In the second place, the term arouses so much prejudice in the minds of most medical men that they never try to see what lies behind this cry. In connexion with their profession, the first thing that comes to their mind is medical treatment, for that is what they are chiefly concerned with in their everyday life. They look round and see that everyone has full opportunities of receiving medical treatment (*vide* report of Federal Committee, January, 1913), and they grow impatient with talk about a term of the meaning of which no one has any clear idea, and concerning which everyone has a different scheme, based on different ideas of the situation and its needs. So they often overlook the fact that, behind this vague and confused talk, lies an idea with which they are in perfect agreement. For there is no doubt that, at the back of talk, all of which is vague and much of which is ignorant, lies the thought on the part of the public that the health of the nation is a national asset, which ought to be conserved more than it is, and which it is a national duty to conserve. And because the public are talking from this point of view, which is a somewhat new idea to them, but a commonplace one to us, they, in their turn, become impatient with the medical profession for doing nothing but point out the apparent impossibility of nationalizing treatment of the sick. There is no doubt that, while individual medical practitioners are trusted and respected by their patients and others, the profession as a whole is distrusted by the public. And one of the causes of the distrust is the misunderstanding to which I have referred. The public think the profession has a monopoly which it has no wish to get rid of. They forget that, after all, it is the discoveries and teaching of medical men (often in the face of great opposition) that has made this dream of national health at all possible of realization. It is most important that we should break down this wall of distrust that separates us from the public. It is most important for us to face the fact that, by educa-

¹ Read at a Meeting of the South Australian Branch of the British Medical Association on November 15, 1918.

ion and training, we ought to be the skilled advisers of the Government and able to convince them that on this fundamental principle we, as a profession, are in absolute accord with the public.

It is as a means to this end that I think we should discuss a national health service and emphasize certain points in it that we are apt to overlook.

For the maintenance of national health four things are fundamentally necessary. We need some sort of machinery to secure:—

- (1) Research.
- (2) Prevention of disease.
- (3) Maintenance of personnel of the medical profession.
- (4) Treatment of the sick.

Those medical men who are perfectly satisfied with our present individualistic methods of doing things remain in that state of mind because they concentrate their attention upon the last of these four. In considering the question of an individualistic system, as opposed to a national system, I wish to-night to emphasize rather the other three points, which we are apt to overlook. We shall then see, I think, that, considered as a whole, the present system of medical service is not so satisfactory as we sometimes suppose, that the public want is not so well served as it might be by the introduction of some fresh methods, and that both the public weal and the welfare of the profession will be served by our organized methods of combating disease coming more into line with the trend of modern medical thought.

Research.

I am convinced that one of the crying needs of our country is medical research. As a profession we know how necessary this is, if we are to learn more of the real nature of even such common diseases as nephritis or pneumonia, which exist here, in common with all the world. But, apart from these world problems, we have those which are all our own. In a striking presidential address before this Branch some years ago, Dr. Marten pointed out the difference in type between well-known diseases in the old world and the same diseases here. Practically nothing has been done to investigate these differences and the reason for them. Forty years ago Dr. Thomas and Dr. Gardner, by their investigations, threw a flood of light on the life history and treatment of hydatids. What has been done in our own State in the way of research since? Practically nothing. About the same time in Queensland, Bancroft investigated the nature of filariasis. In that State practically the only research work done of recent years has been in the Institute of Tropical Medicine in Townsville, established partly by Federal and partly by State Government. In New South Wales the only striking research work carried out of late years is by Dr. J. B. Cleland and his colleagues in the Department of Microbiology. In Victoria we have had of recent years various investigations by members of the staff of the Melbourne University. In Melbourne, also, the newly-established Commonwealth Serum Laboratory is making provision for original research work; but so far that is all. The institutions mentioned all exist for utilitarian purposes, and research, so to speak, is a side-line. For it is doubtful

if the Commonwealth would have sanctioned the establishment of a Serum Laboratory if there had not been a fair prospect of it paying. By the Eliza Hall Bequest I believe there is a scheme for pure medical research at the Melbourne Hospital, the operation of which has been delayed by the war. And in Victoria, at any rate, certain Government research scholarships are offered annually. But all these facts emphasize the three points I wish to make:—

- (1) How little pure medical research is provided for in Australia.
- (2) How few opportunities are given to young graduates to go in for research work.
- (3) How the position as regards research has changed from a generation ago. Then we had individuals doing private research work; practically all that has been done of recent years has been done in connexion with Government departments.

From the very nature of the case, this must be more and more the case. For increasing knowledge reveals to us how exact observations have to be as the problems to be investigated become more abstruse, and therefore the apparatus required and the leisure are quite impossible to the individual practitioner. From the nature of things we have no wealthy class with the educational traditions of generations behind them, such as has arisen in America. Our universities are State institutions; our laboratories are Government bodies. But recent events have shown that for many of our problems State institutions are not much more serviceable than an individual. When we were anxious, as an early result of this war, to find out the possibilities of our own species of fresh water snails being infected with bilharziosis—this was not a State but a national question—there was no machinery available to set to work to secure the information. When the return of malaria-infected troops made the possibilities of malarial infection an important question, an official had to be borrowed from the Tropical Institute of Medicine to investigate the Valley of the Murray and ascertain the distribution of the anopheline mosquito. The so-called "X" disease was first noticed in Broken Hill and investigated there; spread elsewhere in New South Wales and was investigated by Government officials; spread to Queensland and was worked at there by the staff of the Tropical Institute. I have seen at least two cases in South Australia—one imported from Broken Hill, but the other apparently from Renmark. But no one man has been in a position to investigate the whole Australian question, for fear of rousing inter-State jealousy.

These and other instances show that the time has come when we need, and need badly, a national machinery for the encouragement of research on these and other matters that urgently need investigation.

The Prevention of Disease.

Seeing that medical men have always been in the van in discovering and teaching the methods of preventing disease, that medical officers of health are engaged throughout the country in carrying out acts and regulations framed by medical men, it ought not to be necessary to enlarge on this next point, but for the fact that I am sure that many of us have not yet

realized how the events of the past few years have increased the scope of preventive medicine a hundred-fold. This war has shown that it is possible practically to prevent typhoid fever in the largest forces ever seen in the field, composed of individuals who are at the same time living under the most favourable conditions for its incidence. Why, then, is it not prevented in civil life? Why are we taking no steps to prevent it? Leave on one side those diseases which we have been accustomed to regard as infectious and therefore preventable. Let any specialist think of the conditions he sees in the eye department, or the gynaecological department, or the skin department, and reckon how big a proportion of these are due to venereal or other preventable diseases. In general medicine, the modern theory of focal infection has brought a whole series of diseased conditions within reach of preventable diseases. Why has the mortality for puerperal fever in this State remained practically constant for the past ten years, and why has the death-rate for all puerperal conditions decreased so slowly throughout Australia? (*vide* report on Maternal Mortality by Federal Committee). Why can no concerted action be taken to bring this about? Take, again, the preservation of infant life: Is not this a national question rather than an individual question? The pre-natal clinics, baby clinics, maternity homes and similar questions which our Branches have recently been discussing. Can these ever be satisfactorily settled, except as their activities are controlled by medical men, and can this ever be done except with a national service? As a matter of fact, we are to-day on these bigger questions just where the profession stood with regard to septic diseases attending wounds when Lister introduced his antiseptic system 40 years ago. Men then deplored the existence of erysipelas and hospital gangrene in their hospitals, just as we to-day deplore the existence of these diseases in our State. In 40 years' time we will look upon an epidemic of any disease in our State in the same way as a surgeon to-day would look upon an outbreak of erysipelas in his wards.

We have already got to the point where we close our country against influenza, just as occasionally a hospital in those days was closed against fresh cases of sepsis. The next generation will be just as much concerned at preventing infectious disease arising within our borders as the past generation has been concerned with preventing septic disease arising in our hospitals. The way to this will be gradual; it is in its essence the striking of a balance between what the public will put up with and what common sense the medical profession are prepared to show.

Now, it is quite evident that this also is not the business of the general practitioner. It is also becoming increasingly evident that it cannot satisfactorily remain a State matter. The small-pox epidemic in 1913 in Sydney showed how easily State and national interests could clash, and how inevitably the nation was bound to take control. How much longer can a system endure where the national authorities exclude syphilis and gonorrhoea from Australia and leave it to the option of the States as to the action they adopt within their borders? How long will the Federal Government go on paying invalid pensions to tubercular patients while State Governments can do as little as

they please to prevent these pensioners being foci of infection? Here, then, as well as in research, we want a national policy.

The Maintenance of Personnel.

Recent events have shown us how necessary a national policy is on this matter. We have been brought face to face with the strange position of certain State Governments of Australia paying large sums to universities to provide proper training for medical men, and of any State Government being able to introduce legislation offering a premium to men with a much lower standard of education to come in and compete with those locally trained.

When this is duly appreciated we realize the still greater anomaly of States paying these sums for training of medical men, and even paying men to be trained, by the plan of bursaries and scholarships, and then taking no steps to maintain the efficiency of this class that has been trained in scientific medicine. There is a still further anomaly that, while they are paying certain students to learn medicine, the State at present takes no interest in ascertaining whether they are properly trained; also, that in one State we have a six years' course, in others five. The prevention of disease has advanced by strides during the past generation, yet the students get no direct teaching on how to prevent disease. In this respect the curriculum of our own University stands just where it did 20 years ago. There is evidence that the whole question of medical education is about to be thrown in the melting-pot. Proof of this is found in the memorandum recently addressed by Sir George Newman to the President of the Board of Education in England and the interest this has aroused. We are told that our universities know what to teach if the Government would give them facilities for teaching and most *à propos* to our subject are the words of Professor Starling, come to hand this week (*British Medical Journal*, September 7, 1918, page 258): "Hitherto one of the main obstacles to reform of medical education has been the lack of interest, or even the fatuous self-satisfaction in things as they are displayed by all grades of the profession. Each medical man has been interested only in his patients, and the point of view even of the leaders of the profession has rarely extended beyond the walls of their own medical school. Three-quarters of the medical teachers in London are probably of the opinion that all would be well in medical education if only their particular school could receive larger grants in aid of its educational work."

Medical Treatment.

I have left the question of ordinary medical attendance and treatment to the last, because it is the one members think most about, because it is the one least needing immediate attention, and because it simply bristles with problems which are so difficult of just and permanent solution that to attempt to consider the matter from this point of view alone, as is usually done, invariably leads to heated argument or despair. At present I can see no hope of any immediate solution of these difficulties, whatever the future may hold. There is not even a chance of agreement among members of the profession themselves. At the one end we have those who see no great need for any alteration,

at the other those who (as a young practitioner said to me the other day) "would be content with a much smaller income if arrangements were made for an eight hours day, with men working in groups of three, so that work at night came only once in three weeks." Between these two there is a great gulf fixed. One man sees that the public wish to maintain their liberty of choice of medical attendant, the other that, under the present system, a great deal of the time and energy of the medical man is wasted. Can you in any way bring these two points of need together into a practical scheme?

Of patients to be treated, there are the well-to-do, those in moderate circumstances, and those who are destitute. On the other hand, there is private practice, contract practice in its various forms and specialism.

There is no doubt ample opportunity for all to receive treatment, but whether that treatment is efficient is another question. No system like the present lodge system can ever be efficient, because the viewpoint of patient and lodge official is merely that of medical attendance, without any question of efficiency. There is no inducement to carry out the doctor's instructions, if they are irksome. On the other hand, will the public as yet submit to official authority? Thus, no improved system of treatment is possible until the Government are prepared to buy out friendly societies. I can see no reason why a man should not be paid so much per head by the Government, just as by the friendly societies. On the other hand, there is the fear that the Government would sweat the medical profession and we have not sufficient recognition of the fact that sweated medical labour is ineffective and wasteful. It certainly is anomalous to find unskilled labour classed as worth 10s. 6d. a day, or £150 a year, while medical appointments to the Education Department are sometimes advertised as carrying a salary of £400 to £500 a year. On the one hand, we want to cut out the canker of commercialism that is sapping the life of the profession. On the other hand, we want to establish the principle that medical work is duly and adequately rewarded. Nor is it merely a question of making Government servants of medical men. The hospital question still has to be settled, the position of nurses, of dentists, of chemists, of midwives, of masseurs.

All these things make it quite evident that for the present it is best to leave treatment alone and confine ourselves to those other points in which the need for action is more urgent and the field more open for experiment and the results more speedy and certain. Can anything be done to attach the solution from other defects? I believe it can, and that, for some reasons, the time is peculiarly opportune at present. For one thing, owing to the war, the public has got more used to the idea of Government control for prevention of infectious diseases. For another thing, the Government is pledged to a repatriation policy. It is often forgotten that there are medical men to be repatriated, just as much as farmers. While the profession are prepared to raise funds to assist its members to return to their practices, there are plenty of men who have only just graduated. It is just as much a national obligation to spend money in starting them

as in purchasing farms, especially if, at the same time, a move can be made towards a national health service.

I am quite certain that no full-fledged programme can be hatched straight away; it would not be worth putting in the incubator. Whatever is done must be done gradually and on broad outlines. There are certain things that could be done.

It could be laid down by us as a profession that the health service needs to be national. I would suggest that the following resolutions should be forwarded to the Federal Committee for approval:—

- (1) That, in the opinion of the medical profession, the best interests of the public will be better served by endeavouring to build up a health service than by interfering at present in any way with arrangements for the treatment of the sick.
- (2) That any health service must be of a national character.
- (3) That a Minister of Health should be appointed as soon as possible, whose special function should be the control of all activities connected with public health.

If it not yet advisable to have one man set apart for this duty only, the title should be added to the functions of an already existent Minister. At present the Quarantine Department is under the control of the Minister of Trade and Customs, and any public health questions are dealt with by him, but the fact that this is an almost unrecognized item in the duties of so large a department shows how money is the present point of view.

- (4) That, under this Minister, a Department of Public Health should be formed as a Federal Department.

I am not quite sure whether it is the better policy to have a permanent board or a single director at the head of this. The recent history of Naval Boards and Harbours Boards makes one pause; on the other hand, the experience in certain States with a solitary chief officer of health has not always been a happy one. This point brings out the importance of the personnel of these executive heads and of their being not only efficient but *persona grata* to the profession as a whole.

If nothing else could be done in this direction for the present, a standing committee to watch and guide public health questions could be established. What can be done in this way is shown by the Reports on Invalidity in the Commonwealth, drawn up a year or two ago by the committee appointed by the Federal Government. It consisted of Sir Harry Allen, Dr. Jeffreys Wood, Dr. Cumpston and Mr. Matthews. In this selection the scientific, the clinical, the administrative and the political sides were represented, and its useful work gives an example of the lines which should be followed in appointing a permanent board or committee, with the addition of a financial representative. The bulk of such a committee should be medical men. They should be appointed by the Government in consultation with the medical profession. All medical questions should be dealt with by them with due reference to the financial authority.

Failing any other arrangements being possible at present, it would, I think, be wise for the Federal Committee at its meetings to have a regular session with representatives of the Government or Parliament, so that these questions could be discussed from both sides and a way for agreement sought.

- (5) That small pathological laboratories should be established straight away in various small country centres,

They could be arranged judiciously, so as to serve certain districts. In our own State, for instance, the establishment of such laboratories at Port Augusta, at Port Pirie, Wallaroo, Port Lincoln, Burra and Narracoorte or Mount Gambier would put facilities for examination of specimens and body fluids within easy reach of country men. Their interest in the thorough investigation of their cases would thus be stimulated, and so better work would be done. This would also give a golden opportunity of settling a proportion of returned men in a field of medicine, where there would be no clash with other interests and where fresh fields would be cultivated. These men might have a post-graduate course before they returned, in order to fit them for this. Certain men who have acted as orderlies in the Australian Army Medical Corps might be trained as attendants to such laboratories. Military experience has shown that a start can be made with a comparatively simple equipment and building, and additions can be made as needs grow. Too often, in thinking of these matters, we fail to realize that an imperfect building and equipment are better than nothing at all.

In connexion with this a small infectious hospital for that district ought to be established, either under the same man or a close associate with him and his laboratory. The old type of hospital building ought never to be repeated; cheap, open-air structures of the military type could be erected at small cost. And with the end of the war numbers of these will be available, and would be better transported to country centres than thrown entirely on the scrap-heap. In centres where this was not necessary nor wise, arrangements could be made at first by which the whole-time man could work in association with the Quarantine Department or with the Education Department as regards inspection of school children. Then, gradually, as duties increased, another man could be added and the work separated.

In this way the whole-time man could supervise the control of infectious diseases for the whole of the district which the laboratory serves. For this purpose experience has shown that it is absolutely necessary to have whole-time men, free from local influence. The backing of such a man, close to the spot, would be of enormous service to the country practitioner trying to get abuses righted.

The objection that this would clash with State interests could be met in various ways. To mention only two: either new legislation might be introduced or the principle introduced in connexion with venereal disease of subsidizing State expenditure might be extended and the Federal Government subsidize any State money spent in any district. For instance, Port Pirie has recently applied to the State Government for an infectious diseases hospital. The Commonwealth might subsidize the proposal by putting up a laboratory in connexion with it and appointing a whole-time officer to see that the money was satisfactorily expended. Something of this sort would follow as a natural corollary if the Federal Government simply introduced legislation refusing pensions to tuberculous persons in States where there was no control of infection.

There is no doubt that State health officers would have to sink certain prejudices, but I think they are

quite big enough even to do that in the bigger interests of the public health, which they have so much at heart. The difficulty would be largely overcome if we could once get this idea implanted in our minds of a band of men each in his corner fighting disease, much the same as has been done for the past few years in the army overseas. There need be no attempt at uniformity; the British mind seems rather to work best by special efforts made according to local needs yet correlated loosely to a central authority.

The establishment of these laboratories and hospitals would gradually build up a service in which opportunities for promotion to bigger centres would occur as the result of fruitful or original work done in these smaller centres.

The Federal Government should further make a special policy of offering a fair number of research scholarships to be used under the director of this central committee or department in the larger city laboratories and hospitals. Preference might at first be given to returned men. Later young graduates would look upon this as a post-graduate offering. In this way a band of scientific workers could be built up.

These may be but small beginnings, but they would be a start at solving three present difficulties: lack of research, lack of machinery to prevent disease and openings for returned young practitioners. I have for years been impressed by a saying in a letter of John Hunter to Jenner: "Do not think, try; be patient, be accurate, for that, after all, is the scientific method." We have talked about this matter, but it would be better to try in a small way at first and attack one side of the problem. Then we should probably find, as in other matters, that other aspects of the problem became more easy of solution as we got closer to them and attacked them one by one, instead of trying straight away to launch a complete scheme that would deal with every difficulty.

EMERGENCY SURGERY.

Notes on 166 Consecutive "Immediate" Operations Performed at the Melbourne Hospital.

By Athol S. M. Tymms, M.D., M.S. (Melb.),

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(Continued from page 429.)

Whilst Registrar at the Hospital some years ago I met with a similar condition of toxæmic jaundice in a case of acute-ulcerative endocarditis in a female, in whom a diagnosis of acute cholecystitis had been made.

It will be seen that the deaths were found among the patients in whom the duration of the illness had been longer than seven days, and each presented a special feature to account for the fatal ending. Thus in one, the great age; in another, the severe type of infection; and, in the third, the unusual position and train of symptoms, mitigated against a successful issue.

Diverticulitis of the Large Intestine.—Under this heading are included three cases. William J. Mayo,

of Rochester, in a paper read at the Annual Session of the American Medical Association in 1917, dealt with a series of forty-two cases in which he had resected portion of the large intestine for this condition. Cases that were operated upon for abscess (peritonitis), etc., without resection he did not include, because the presence of the diverticula was not proved. The diverticula were of the acquired type, *i.e.*, protrusion of the mucous membrane through small openings in the musculature of the bowel. One or two diverticula were usually responsible for the diverticulitis or peri-diverticulitis, though the condition could affect a large portion of the bowel. The majority of the patients were over 50 years of age, and very obese, with increased deposits of fat in the abdomen. There was usually constipation, with left-sided pain simulating appendicitis, and very frequently a history of distension and swelling in the left iliac fossa. He recognized the following classes:—

- (a) Self-limiting diverticulitis, with peri-diverticulitis.
- (b) Diverticulitis and peri-diverticulitis, with abscess and fistula.
- (c) Diverticulitis, with obstruction (acute or chronic).
- (d) Carcinoma, associated with diverticulitis.

He found that carcinoma often co-existed with diverticulitis, and regarded the latter as a precursor of cancer.

Differentiation between carcinoma and diverticulitis could be established by the incomplete character of the obstruction in diverticulitis, and by the X-ray and the sigmoidoscopic examination.

Of the three cases met with as requiring immediate operation, two were in males and one in a female.

A very obese man, aged 54 years, was admitted with the diagnosis of acute appendicitis, with general peritonitis. His symptoms had been acute, and there was no loss of weight. When the abdomen was opened pelvic peritonitis was discovered, and a large loop of thickened sigmoid, with adhesions, was recognized, with excessively large and fatty *epiploicae*. The caecum was collapsed, with the appendix adherent to it, but there were no signs of recent inflammation. The small intestine was slightly distended from peritonitis, whilst the bowels had acted quite freely several times daily without any blood, mucus or pus. No cause beyond the inflamed and thickened condition of the sigmoid, with its surrounding peritonitis, could be found to account for the condition present, and the pelvis was therefore drained.

No increase in the distension occurred after operation, and the bowels had acted very freely, the patient now being well on the way to recovery. There were no enlarged glands, and the condition did not feel like carcinoma. It was, therefore, regarded as a case of acute peri-diverticulitis or sigmoiditis. Whether the condition will eventuate in carcinoma will be awaited with interest.

A female, *æt.* 31 years, presented a similar condition, but the peritonitis was more advanced, the distension more marked, whilst the amount of fat was even greater. The many *epiploicae* were covered with lymph and the appendix was adherent to a collapsed

caecum, and showed no signs of recent inflammation. A second operation the following day, for increased peritonitic distension, when an enterostomy was performed, using a Meckel's diverticulum that was present, allowed of further investigation as to the cause of the condition, but disclosed no thickening in the large bowel, nor cause for peritonitis other than the peri-sigmoiditis. This patient died, and it was unfortunate that permission for a post-mortem examination was not obtainable.

The third patient, a male, aged 64, was operated upon in the belief that he was suffering from general peritonitis from a perforated appendix. He had had pain and swelling in the left iliac fossa, was very obese, but not constipated. The abdomen was opened, and general peritonitis, with thick, dirty, brown fluid, was found, of non-faecal but rather sour odour, suggesting gastric contents. A large, thickened sigmoid loop occupied the mid-line, covered with very large, excessively fatty, lymph-covered *epiploicae*. On tracing this upward the thickening was found to extend along the descending colon towards the splenic flexure, where it gradually ended, and on the medial side of the gut, just at the termination of the descending colon, was a sloughing, gangrenous *epiploicele*, with an opening into the bowel, from which the contents were escaping. So thick and friable was the bowel tissue that closure was not possible, and in the presence of the advanced peritonitis it was thought desirable to pack and drain, at the same time bringing up a loop of small bowel into the wound, as in the first stage of an ileostomy. This was opened later, and afforded relief to his distension; but he died on the seventh day from peritonitis and toxæmia. Though he had been slightly jaundiced, this disappeared after the operation. The upper segment of the abdomen was clear, and at the post-mortem examination the sigmoid and descending colon were removed. The walls of the sigmoid (particularly the ileac portion) were greatly thickened, with great increase of the fatty deposit, but the lumen was not greatly constricted, nor was the mucous membrane ulcerated. Above this was the sloughing perforation. The thickening diminished towards the upper part of the descending colon, without any dilatation of the bowel. Microscopical examination of the bowel thickening disclosed it to be a chronic inflammatory condition, with no sign of carcinoma. Further investigation of the specimen has, up to time of writing, not been completed.

(iii.) Peritoneum.

The condition that has been included here is that of tuberculous peritonitis. There were two cases, each differing in character and in regard to diagnosis. One was presented as an obstructed incisional hernia (Battle incision), but under the anæsthetic this disappeared, and while the abdominal walls were being repaired the abdomen was found full of dirty, yellowish, stringy, odourless fluid, and tuberculous calcified lymph glands were observed in the ileal mesentery.

The second was admitted as a case of intestinal obstruction, possibly malignant, though the patient was only 34 years of age. He was markedly emaciated. The abdomen was filled with a slightly turbid fluid and the bowel was slightly distended, but no tubercles, ulcers, or enlarged glands were observed,

and exploration revealed no apparent cause for this condition. The affection was regarded as an instance of tuberculous peritonitis of somewhat acute type.

(iv.) *Gall Bladder and Ducts.*

The common surgical condition met with under this heading was that of cholelithiasis. The inclusion here, instead of under pancreas, of two cases might be questioned, but in the presence of the calculi the contributing cause was not far to seek.

Five females and two males were found at operation to have gall-stones. Their average age was 48 years, the youngest 38 and the oldest 64.

A girl, aged 20, not in this series, operated upon under a diagnosis of appendical abscess, had a large gall-bladder, situated in the right iliac fossa, packed with calculi.

Four patients had been, or were, jaundiced prior to operation. Three of them had calculi in the common duct, one associated with carcinoma of the pancreas. In one case jaundice was due to chronic pancreatitis, with calculi in the gall-bladder, but not in the ducts. Three patients had no jaundice, and only the gall-bladder contained calculi. In two cases sent for operation the diagnosis was appendicitis.

The calculi varied both in size and number. In one case three large, only slightly faceted calculi were found in the gall-bladder, whilst in another 91 calculi, mostly faceted and small, had been removed. In the three without jaundice the gall-bladder contained 12, 29 and 53 calculi respectively; but in each it was noticeable that the cystic duct was blocked by one rather large, ovoid, non-faceted calculus, though the remainder were small and faceted.

When calculi were small, numerous and faceted, they were associated with a considerable quantity of gritty substance, and jaundice was present from the passage of these within the common ducts. Cholangitis was a marked feature of the cases, with chronic pancreatitis and carcinoma of the pancreas.

Two patients had been operated on previously by a surgeon for a similar condition; one had had two operations. At the first of these, six years before, 91 calculi had been removed from the gall-bladder, which was drained, and at the second, four years later, one non-faceted calculus had been obtained from the gall-bladder and two faceted calculi from the hepatic ducts, both the duct and the bladder being drained. A sinus had persisted for twelve months. She returned with jaundice, and on this occasion a single soft calculus was removed from the common duct, both duct and gall-bladder being drained. The wound healed in three weeks, and the patient is quite well.

Another patient had had an operation some four weeks previously by a surgeon, who removed a portion of the gall-bladder along with some calculi, a drain being inserted to the stump. Though then not jaundiced, she had suffered from icterus six months and again three weeks prior to that operation. At the emergency operation an abscess was opened through the original wound and a tube inserted into the cavity between the liver and transverse colon. After convalescing from this, she had a return of the colic and jaundice, and at the operation a calculus was removed from the distal end of the common duct, and the duct was drained. In both these cases considerable time was expended in the search for the duct,

owing to the mass of adhesions resulting from the previous operations.

The importance of a systematic and thorough exploration of the ducts at the primary operation can therefore be appreciated. It is in cases of multiple small calculi in the gall-bladder that particular care in this respect should be used. The presence of a rather large, non-faceted calculus in the neck of the bladder or the cystic duct, without jaundice, would be evidence against the diagnosis of calculi in the ducts, even though the gall-bladder were otherwise full of smaller calculi. But though the presence of calculi in the ducts is chiefly due to their escape from the gall-bladder, in addition, calculi may form in the ducts themselves, and it should be remembered that occasionally a recurrence (newly-formed calculi) may occur.

In none of these cases was the gall-bladder removed. It had been partially removed at a previous operation in one case, and a microscopical examination showed a chronic inflammatory condition. In addition to cholecystostomy, two cases had choledochotomy performed after the removal of the calculi from the ducts. In none did the conditions appear to call for cholecystectomy.

Three patients died, all later than a week after operation. One of the two females developed acute mania on the second day, and in spite of her violent behaviour, necessitating restraint, her wound healed by the twelfth day, but she died from exhaustion on the fifteenth day.

The second female was jaundiced, and after removal of three large calculi from the gall-bladder and draining, the jaundice cleared up, but the stools remained pale. There was no glycosuria. She died on the twentieth day, and the autopsy disclosed chronic pancreatitis, with cholangitis, but no calculi in the ducts. Possibly this was also a case of carcinoma, as no section was examined. At operation enlarged glands were felt in the gastro-hepatic omentum.

The third death was that of a man who was admitted acutely ill, with intense jaundice and pain. The gall-bladder contained 56 small calculi, but was not distended. Calculi were thought to be detected in the common duct, but the condition of the patient was too critical to warrant their removal. Cholecystostomy alone was performed. He died on the seventh day. The post-mortem examination disclosed a carcinoma of the pancreas, cholangitis, with calculi impacted in the ducts and hypostatic pneumonia.

(To be continued.)

Reports of Cases.

SHORTENING OF THE UTERINE LIGAMENTS IN RETROVERSION OF THE GRAVID UTERUS; FIFTH SUCCESSFUL CASE.

By William T. Chenhall, M.D., F.R.C.S.,
Honorary Gynaecologist, Royal Hospital for Women, Sydney.

History.

F.M., aged 34 years, was admitted to the Royal Hospital for Women on November 6, 1917. The youngest of her six children was two years of age.

The patient complained of nausea, anorexia, headache, irritability, backache and pelvic discomfort, with frequency of micturition and a feeling of pressure against the bowel during defecation.

The anamnesis, presumptive and positive signs revealed a two months' pregnancy, with uterine retroversion and *descensus*, and relaxation of the vaginal outlet.

The Operations.

(a) The relaxed outlet was repaired by the butterfly incision method, No. 2 chromic catgut being used for the crown suture and plain sterile catgut for all other sutures.

(b) The abdomen was opened in the middle line by a short incision well below the umbilicus. The incision struck the mid-line, accurately separating the two recti muscles, which, in this position, lie closely together.

With good elevation in the Trendelenberg position, the uterus was easily located and the ligament on each side defined. The uterus itself was not touched.

A strand of No. 2 chromic catgut was passed on a round, curved needle beneath each round ligament, at a distance of 5 cm. from the uterus. The two ends of each suture were grasped by a pair of forceps.

At a level 3.75 cm. above the crest of the pubes a thin, curved forceps was passed laterally beneath the sheath of the rectus muscle until it reached the body of the muscle. It was then made to pierce the muscle, subperitoneal tissue and peritoneum, to pick up the two ends of the corresponding suture and to withdraw them along the track. This procedure was repeated on the other side.

The omentum was carefully drawn down over the intestines and behind the uterus, and the peritoneum closed.

The two ends of each suture beneath the ligament were then attached to the cut margin of the sheath of the rectus muscle of the opposite side.

The omentum was very carefully extended over the intestines and pelvic colon and behind the uterus. Each layer of the abdominal wall was then closed in series, No. 2 chromic gut in continuous suture being used for the sheaths of the recti and No. 1 chromic gut as a subcuticular suture for the skin.

Post-operative pain was controlled by morphine, and digestive disturbances were guarded against by strict limitation to a proted dietary of small amount for a few days.

Perfect union of the incision resulted, and convalescence was easy and normal.

The Result.

On June 16 the patient gave birth to a male child, 9½ lbs. in weight, a nurse only being in attendance.

Two weeks later the mother, accompanied by her nurse and child, walked into my consulting-room.

The abdominal incision, purposely made as short as possible, was perfectly healed, the recti muscles being in normal apposition. This I attribute largely to the careful use of an obstetric support during her carrying period, in addition to careful suturing of the wound.

The vaginal outlet was intact.

Commentary.

I believe this procedure, in carefully selected cases, perfectly justifiable. Truly, five cases do not constitute a critical test, but each one has proved in the highest degree successful, and in each one *post partum* examination has revealed normal apposition of the recti muscles and a maintenance of the corrected position of the uterus.

The insertion of a pessary as a temporary support after operation is unnecessary. Guard against undue effort is imperatively demanded during the early weeks after operation, but once the uterus rises out of the pelvis and enjoys extrinsic support walking is distinctly beneficial, by establishing normal muscular tone and functional activity.

The operation is not difficult, but demands scrupulous care, and, above all else, the uterus must not itself be touched. Even retro-uterine peritoneal adhesions may be divided without handling the uterus if the organ be supported by the tractor sutures passed under the round ligaments.

I would claim that the operation in some cases will guard against abortion threatened by the uterine displacement, especially when this is aggravated by adhesions. Further, it will avoid the insertion of pessaries, themselves disgusting in clean obstetric practice.

A pessary will prove as useless, when the pelvic outlet is relaxed, as it will prove harmful when the foundation is intact but adhesions exist.

I regard the operation as a conservative, hence justifiable, procedure, in carefully selected cases—nothing more, nothing less.

Pioneering work seldom has a true precedent for guidance.

Contraindications do not require statement. They are known to experienced surgeons, who alone should attempt the task, and who may with confidence add the procedure to their armamentarium and apply it when their judgement so warrants.

Public Health.

NEW SOUTH WALES.

The following notifications have been received by the Department of Public Health, New South Wales, during the week ending November 16, 1918:—

	Metropolitan District.		Hunter River District.		Rest of State.		Total.	
	Cs.	Dths.	Cs.	Dths.	Cs.	Dths.	Cs.	Dths.
Enteric Fever ..	7	1	0	0	5	0	12	1
Scarlatina ..	6	1	1	0	1	0	8	1
Diphtheria ..	11	0	0	0	29	0	40	0
*Pul. Tuberculosis	14	9	6	5	33	0	53	14

* Notifiable only in the Metropolitan and Hunter River Districts, and, since October 2, 1916, in the Blue Mountain Shire and Katoomba Municipality.

VICTORIA.

The following notifications have been received by the Department of Public Health, Victoria, during the week ending November 17, 1918:—

	Metropolitan.		Rest of State.		Total.	
	Cs.	Dths.	Cs.	Dths.	Cs.	Dths.
Enteric Fever..	1	0	2	1	3	1
Scarlatina ..	27	0	15	1	42	1
Diphtheria..	71	1	56	0	127	1
Pulmonary Tuberculosis	15	5	13	5	28	10

QUEENSLAND.

The following notifications have been received by the Department of Public Health, Queensland, during the week ending November 16, 1918:—

Diseases.	No. of Cases.
Enteric Fever..	8
Scarlatina ..	7
Diphtheria..	32
Pulmonary Tuberculosis	11
Cerebro-Spinal Meningitis ..	1
Erysipelas ..	1
Puerperal Fever ..	1

SOUTH AUSTRALIA.

The following notifications have been received by the Central Board of Health, Adelaide, during the week ending November 2, 1918:—

	Adelaide.		Rest of State.		Total.	
	Cs.	Dths.	Cs.	Dths.	Cs.	Dths.
Enteric Fever..	0	0	1	0	1	0
Scarlatina ..	1	0	12	1	13	1
Diphtheria..	0	0	23	0	23	0
Pulmonary Tuberculosis	4	3	6	1	10	4
Erysipelas ..	0	0	3	0	3	0
Morbili ..	0	0	10	0	10	0
Pertussis ..	7	0	32	0	39	0
C'bro-Spinal Meningitis	0	0	1	0	1	0

The Medical Journal of Australia.

SATURDAY, NOVEMBER 30, 1918.

The Treatment of Returned Men.

Mr. Roy N. Teece has recently called public attention to the manner in which the Board of Management of the Sydney Hospital has failed to recognize the just claims of a medical man who has won golden opinions in the service of the Empire. The facts concern the appointment of the Medical Superintendent of the Hospital. Early in the course of the war one of the members of the resident medical staff enlisted for service in the Australian Army Medical Corps. He had performed his duties at the Hospital in a most excellent manner. He was appointed to regimental duties and served first in Egypt and later in France. As far as his military record is concerned, it may be sufficient for our present purpose to relate that he was mentioned in the despatches on account of conspicuous bravery and devotion to duty, that he was promoted from Captain to Major and from Major to Lieutenant-Colonel, and that he was awarded the Distinguished Service Order for fearlessness and magnificent service in the field. From the point of view of experience, it may be recalled that he held important administrative positions, which he filled with great distinction, and that his war service provided a perfect equipment for the position of medical superintendent of a large public hospital. The Medical Superintendent of the Sydney Hospital was unfortunately compelled to resign his office on account of ill-health. The vacancy was advertised in the public press a few weeks ago. In this connexion we would urge that it is in the interests of the medical profession, and simultaneously of the public, that advertisements calling for applications from medical practitioners for vacant positions in public institutions should appear in *The Medical Journal of Australia*, in order that every member of the British Medical Association throughout the Commonwealth should be informed of the vacancies. Advertisements of this character in the lay press

are frequently overlooked by medical practitioners, and it is obviously desirable that the doctors' newspaper should be the place wherein this form of announcement should appear. The vacancy referred to was not advertised in this journal, and we are informed that a public advertisement was agreed to only after strong representations had been made that it was necessary. The selection of an officer was narrowed down to two applicants. The one was the medical man referred to above, while the second was a medical practitioner who had joined the resident medical staff of the Hospital after the first candidate had joined the Australian Imperial Force. This practitioner was holding the position of Acting Medical Superintendent at the time of the election. He had applied for a commission in the Australian Imperial Force previously, and had been rejected for physical reasons. Moreover, he had discharged his duties in an admirable manner. But the fact remains that the one man had been on active service and the other had not. The Board of Management considered the qualifications of the two candidates, and by a very large majority elected the then Acting Medical Superintendent.

We recognize that the interests of the patients must be taken into consideration in the selection of a medical officer, and that the returned man may only have the preference if it can be shown that he is competent to carry out the duties attaching to the post. In this instance he was actually senior to the successful candidate; he had performed administrative duties of a very responsible character and had gained the complete confidence of those in authority. It was therefore unquestionable that his records were favourable to his appointment. The Board of Management must be compelled to reconsider their decision. The public demands that, "other things being equal," preference must be given to the man who has served his country with distinction. The desires and whims of individual members of a board do not count in matters of this kind. The Board has a serious responsibility, and if it accepts it lightly, the public will intervene. Perhaps the wisest course would be to annul the recent appointment and to appoint the unsuccessful candidate as Acting Medical Superintendent for a period until all our men have returned to Australia. The permanent appointment could then be proceeded with

after due advertisement, and if a better man than the holder applies for the position it could be given to him. The Board must, however, keep the axiom before it all the time: preference is to be shown to those who have served the Empire.

INFLUENZA ON SHIPS.

Australia has witnessed during the past few weeks the most extensive and complete quarantine measure ever carried out in any country. For several months an epidemic of a disease, clinically like influenza, was prevalent in Spain and in Germany and Austria. War has always brought in its trail epidemic disease, and little surprise was felt that the outbreak in this instance should prove more than usually virulent. It spread, as was to be expected, to Great Britain, and manifested the same characteristics there as in the other named countries. Bacteriological investigations carried out in Germany and in England have failed to determine the exact causation of the disease. It is stated that the workers of the Medical Research Committee, under the National Insurance Commission, and Rubner in Germany have found Pfeiffer's influenza bacillus in about one fifth of the cases, while pneumococci of various types, streptococci and a Gram-positive diplococcus have been found in nearly all the cases. The disease was characterized by a sudden onset with extreme prostration, relatively little fever, intense cyanosis, and free hæmorrhages from the mouth, nose and rectum. Soon it made its way overseas. First it invaded America and then South Africa. It appears to have been introduced into South Africa by some workmen brought over in a transport. The mortality was high, and the incidence extreme. From South Africa it invaded New Zealand and, notwithstanding reasonable notice, adequate efforts to exclude it were not taken.

The Quarantine authorities in Australia immediately put into motion the machinery devised to keep infective disease out of the Commonwealth. Ships carrying persons infected arrived at Port Darwin, Townsville, Brisbane, Sydney, Melbourne, Adelaide, Hobart, Fremantle, and Broome, and at each port the cordon was drawn tight. Steps were taken to isolate every person suffering from the disease.

All who had been exposed to infection were kept in quarantine for one week, and in no case was the person permitted to leave the "clean" side of quarantine without having first been treated by means of a spray of the solution of sulphate of zinc. Over 3,000 persons were handled in this manner. There were over 500 patients, and the mortality, thanks to the energetic and efficient treatment adopted, was kept at the relatively low figure of 3.8%. Notwithstanding the fact that the disease could have been introduced from three countries, namely, America, South Africa and New Zealand, it is a remarkable fact that not a single infected person gained an entrance to the Commonwealth. No risks were taken, and the Quarantine authorities did not even fear to incur the displeasure of some of the State officials and of the public, by taking their responsibility most seriously, and refusing to relax their efforts on a single occasion.

While the authorities were carrying out this fine piece of work, and perfecting the organization which rendered success certain, the Director of the Commonwealth Serum Laboratories undertook an investigation into the bacteriology of the affection. We are officially informed that the influenza bacillus was isolated in three cases by Dr. Everitt Atkinson, in Western Australia, and in one case in New South Wales by Dr. Drew. Pneumococci of various types, streptococci and a Gram-positive diplococcus distinguishable from the pneumococcus were isolated in nearly every case examined. Some preliminary difficulty was experienced in the cultivation of the Pfeiffer organism, but the employment of a special medium enabled Dr. Penfold to obtain luxuriant growth in pure culture. In a few cases *micrococcus catarrhalis* was also present. It is not yet possible to announce whether the disease is primarily an influenza or a pneumococcal septicæmia. Further biological investigations are needed to clear up this point.

The medical officers at the several quarantine stations have uniformly found that a vaccine prepared from the bacteria named above (excepting the influenza bacillus) appeared to prevent serious complications, and to reduce the mortality. A similar report has been received from South Africa. A vaccine is now available made from the strains of

these organisms isolated from the cases in quarantine, and the latest issue contains the Pfeiffer bacillus.

The public not unnaturally became alarmed at the risk of someone breaking quarantine, and the disease gaining a foothold in Australia. This alarm became most acute in Sydney, owing to the enterprise of the lay press. As the public demand arose, the State Health authorities sought the assistance of the medical profession in New South Wales, and a number of measures were adopted for the feared eventuality. The wisdom of taking reasonable precautions against an outbreak cannot be challenged, but we cannot regard a general panic with unconcern. The disease is now dying down. But few cases are occurring at the quarantine stations, and the number of infected persons arriving is rapidly diminishing. In another week the Federal Quarantine Service will be in the proud position of having achieved the greatest triumph of its kind in the history of epidemiology.

THE DETECTION OF SPIROCHÆTES.

The Special Committee of the Medical Research Committee appointed to report on the standardization of pathological methods have dealt in their third report with the methods to be used for the detection of the syphilitic spirochæte.¹ It is necessary for every medical practitioner who undertakes the treatment of syphilis to acquaint himself with the details of the diagnosis of this common and serious affection, even if it would be utopian to expect the average general practitioner to possess the apparatus necessary for this diagnosis or the training and practice to enable him to obtain reliable results. Certain cases, no doubt, present such typical symptoms and signs that the diagnosis, when the disease is well developed, is obvious. But even the most typical infection can be, and should be, diagnosed long before the signs have developed. In the earliest stages, the complement fixation test is of no avail; the spirochætes have not yet produced their antibodies. At this stage the diagnosis must necessarily depend on the discovery of the organism in the superficial lesion. The Committee give instructions concerning the proper method of collecting the serum from these lesions for transmission to a properly equipped laboratory, where the examination can be carried out by a practised bacteriologist. The surface has to be cleansed of all debris by means of a wad of cotton wool moistened in saline solution or in tap water. The sore is then firmly squeezed, preferably by the patient himself, until drops of serum exude. At times it is necessary to scarify the surface lightly. If blood be drawn, it is essential to wait until no more flows, since the presence of blood lessens the

chance of the detection of the spirochætes. The serum is allowed to run up into a capillary pipette. When serum is to be collected from the mouth, care should be taken to avoid the inclusion of saliva. Serum can be obtained from papules by scraping away the superficial layers of epithelium and then speezing the lesion. A blister may be required when a macule is being dealt with, and if material is sought from lymphatic glands, it is necessary to inject into their substance about 0.3 c.cm. of sterile saline solution and after massage to apply suction with the piston of the syringe. The aspirated material is ejected on to the surface of a clean microscopic slide and then sucked up into a pipette.

The Committee publish a very excellent account of the dark ground illumination microscope, written by Mr. J. Edwin Barnard, the learned President of the Royal Microscopical Society. We recommend every practitioner interested in the diagnosis of syphilis to purchase a copy of this report, in order that he may obtain a clear, scientific idea of the physics of the three types of dark ground illuminators and the means that should be taken to avoid the warping of images and consequent errors in diagnosis. We would further recommend every practitioner who has not become familiar with the appearance of unstained spirochætes under dark ground illumination, to seek an opportunity of visiting a laboratory where these examinations are made and asking an expert to demonstrate a few good specimens. No illustration in a book or journal can convey the same impression as the real thing.

In addition to the examination of unstained specimens, the Committee recommend the examination of stained films. Unfortunately, drying often causes distortion and at times, even in the hands of skilled microscopists, the syphilitic spirochæte reveals a lack of affinity for staining reagents. They may be stained by Giemsa's methods, by Leishman's method, by the Indian ink and Congo red methods, or by the silver nitrate methods. These methods are very simple of application, but in the hands of inexperienced workers they are liable to yield inaccurate diagnoses. Well-stained spirochætes, if typical, are unmistakable, but even the best specimen lacks the characteristic movement of a living spirochæte. Since the diagnosis of syphilis in its early stages is of paramount national importance, it follows that medical practitioners should submit their specimens in every case to some competent bacteriologist. Unfortunately, too few students are trained to laboratory methods in the Commonwealth. This defect must be rectified in the near future, in order that there may be ample provision for the laboratory diagnosis of disease in every part of the Commonwealth.

Naval and Military.

CASUALTIES.

The 444th, 445th and 446th lists of casualties, which were issued to the public on November 22 and 25, 1918, contain a very large number of names. We regret to announce that among those killed in action is Captain Hugh Edward Kirkland, M.C. Captain Archibald Lang McLean is reported to have been wounded (gas), while Captain Reginald Francis Matters is also mentioned among the wounded.

¹ Methods for the Detection of Spirochætes; Medical Research Committee, Special Report Series, No. 19; 1918. Price 1s. net. (Obtainable of His Majesty's Stationery Office, Kingsway, London.)

Abstracts from Current Medical Literature.

DERMATOLOGY.

(182) Some Uses of Castor Oil in Dermatology.

Douglas Montgomery discusses the value of castor oil in dermatological practice (*Journ. Cutan. Diseases, inc. Syphilis*, September, 1918). Studying the physical characters, it will be noted that the oil is very heavy and resistant to changes of temperature; thus it withstands heating better than most oils, and only solidifies when a very low temperature is reached. Some features of importance to dermatologists are: (1) Its solubility in alcohol. Various medicated alcoholic lotions are frequently employed in the treatment of the scalp, and without the addition of a small quantity of oil the spirit would in a dry scalp dissolve out an excessive quantity of sebum. For this purpose castor oil is the oil which is usually chosen. (2) This oil also facilitates the solution of salicylic acid in oils and ointments, and thus renders it less irritating to the skin. The salicylic acid must first be mixed with a little hot castor oil, and then added to the other ingredients. (3) Lastly, the internal administration of the oil acts particularly on the ascending colon, and as many of the more active skin reactions are caused by poisons generated in the *caput coli*, a favourite localization for the anaerobic proteolytic bacteria, it thus produces a clean alimentary canal, which in turn conduces to a clean cutaneous surface.

(183) Annular Macular Syphilis.

John Rothwell (*Journ. Cutan. Diseases, inc. Syphilis*, July, 1918) describes a case of annular macular syphilis in a male, aged 29 years. When first presenting himself at hospital the patient had a double chancre on the dorsum of the penis, double inguinal adenopathy, enlarged epitrochlear and cervical glands, and stated that he had received nine intramuscular injections of a drug, the nature of which was unknown to him. The cutaneous examination revealed an eruption distributed over the trunk, arms, forearms, hips and thighs, which closely resembled *erythema multiforme* in appearance. The lesions were circinate, non-pruritic, purely erythematous, fading on pressure and directly reappearing, but there was no evidence of scaling. The circles were of a faint pink colour, without infiltration, and measured 2.5 to 5 cm. in diameter, with definite borders 0.3 to 0.6 cm. in width. The centres of the circles were clear, and only exhibited the normal pigment of the rest of the uninvolved skin. In a few instances on the trunk the circinate erythematous lesions were as much as 7.5 cm. in diameter, and in several there were central papules. The patient stated the eruption was first observed

about six weeks after the appearance of the primary lesion, and that in size and appearance it resembled that at present under observation. However, it is probable that the ordinary macular eruption had first appeared unrecognized by the patient, and had developed into the type at present under examination. The Wassermann reaction was positive. The author calls attention to a recent article by Howard Fox, in which he described a case of annular macular syphilis, together with a photograph and review of the literature on the subject. Fox stated that it was an unusual manifestation of the disease, and that it made its appearance in the late secondary or even tertiary period. The point of interest in the present case was the close resemblance of the cutaneous eruption to that of *erythema multiforme*, so that a diagnosis from objective symptoms alone might easily have been incorrect. This similarity to *erythema multiforme* has been reported by other observers, and Hazen observed it in three cases that he had seen, so that, in a patient with persistent *erythema multiforme*, especially in a female, where the primary lesion may pass unnoticed, an examination of the blood is indicated. This form of syphilis is usually regarded as being very resistant to treatment, but in the present case it rapidly disappeared under appropriate drugs.

(184) Combined Röntgen Methods in Gastro-Intestinal Examinations.

Perkins gives a short historical account of gastro-intestinal radiography, commencing with the work of Cannon on animals in 1899 and following up the work of Crane, Rieder, Haudek and others (*Med. Press*, July 31, 1918). Reider gave his first bismuth meal to a human being in 1903, and is thus the pioneer of gastro-intestinal radiography. The author urges the use of combined fluoroscopic and radiographic methods. Only by fluoroscopy can the motility, peristalsis and mobility of an organ be determined and appreciated; by the radiographic method momentary phases in the state of the organs under observation alone are obtained. The examination of the stomach and duodenum after the administration of a watery meal, accompanied by palpation under the screen, is advocated; by this procedure small irregularities of the curvatures are noted and the duodenum is much more clearly defined than is usual with the thicker "motility" meal. Vertical and horizontal examinations should be carried out and palpation practised with the protected hand. The author reminds his readers that clinical findings and radiographic findings must be correlated if the best information is to be obtained. "No diagnosis can be too strongly fortified by all procedures known to medicine, and in justice to the patient we must use every known clinical method of diagnosis, and not rely upon any single examination."

(185) Radiology in Urology.

In an article on recent advances in urinary surgery, J. W. Thomson Walker

deals with the diagnostic and therapeutic uses of X-rays and radio-active substances (*Surg., Gynec. and Obstet.*, August, 1918). He points out in a series of 450 cases operated on at the Mayo Clinic in 18 years the mortality was only 0.6%; 9.9% of the patients had bilateral calculus. The calculi recurred in only 10%. He refers to Burns's work in regard to the use of thorium. The best thorium solution is a double solution of thorium and sodium citrate, with excess of the latter salt and a slight addition of sodium nitrate. A 10% solution is used for cystograms and 15% for pyelograms. The resultant negatives are good, and the shadows cast are dense. The solution is cheap, non-toxic and unirritating, and is also quite limpid. Examinations of the bladder by cystograms have confirmed the opinion that the internal sphincter causes complete bladder closure, and prove that there is no neck or funnel caused by distension of the posterior portion of the urethra. In many cases of infection of the upper part of the urinary tract, spreading from the bladder, it has been demonstrated that there is regurgitation of fluid from the bladder through the uretero-vesical orifice, even when cystoscopy has failed to reveal any abnormality of this orifice. Cystoscopy may reveal a diverticulum of the bladder, but its extent can only be demonstrated by cystography. Dealing with the treatment of carcinoma, Berringer claimed that radium has a marked sclerosing effect, but that it is useless in simple hypertrophy. Radium is incapable of influencing very large growths associated with cachexia. The screened radium is placed in the bladder and left *in situ* for from six to ten hours and repeated when necessary in the absence of severe reaction.

(186) Military Röntgenology.

Percy Brown and John Young (*Americ. Journ. Roentgenology*, September, 1918) call the attention of civil Röntgenologists to the possibility of confusion in the interpretation of Röntgenograms of wounded men, who have been treated by means of the bismuth-iodoform-paraffin paste of Morrison. This "B.I.P.P." casts a dense shadow, which may obscure the foreign body, or may itself cast a shadow like a foreign body. In some cases the shadow of the paste may be dissociated from the shadow of the foreign body by displacement of the tube or by altering the position of the patient.

BIOLOGICAL CHEMISTRY.

(187) Autolysis of Animal Tissues.

K. G. Dernby has studied the non-bacterial, *post mortem* self-decomposition of animal tissues, which is now recognized as due to enzymatic action (*Journ. Biol. Chemistry*, August, 1918). The investigations of this "autolysis" of tissues have been concerned with the products of the change or with the

action and nature of the proteolytic enzymes bringing about the autodigestion. The end-products of the destruction of the tissues are amino-acids, albumoses, peptones and peptides, such as are obtained by the action of pepsin, trypsin and erepsin. The nature and manner of action of the different proteolytic ferments is of biological importance, as it is probable that these autolytic ferments are not *post mortem* products, but are the enzymes which act during the life of the cells. Much attention has been paid to the influence of the reaction upon the material undergoing auto-digestion. Sorensen thinks that it is as important to observe the concentration of hydrogen ion on the eventual changes in a biochemical process as to note the influence of temperature. The author has studied the proteolytic enzymes of the liver, spleen, pancreas, mucosa of the stomach and leucocytes of freshly-killed dogs and pigs. In all these tissues he has demonstrated the existence of peptase enzymes, which split native proteins to peptones, but not further. These ferments cannot act in alkaline or even neutral solution and exhibit an optimal activity when $pH = 3.5$. In all these tissues there are also present ferments attacking only peptones and peptides and splitting these substances into amino-acids. The activity of these ferments is checked in faintly acid solutions, and appears maximal when $pH = 7.8$. In the case of the pancreas and liver it has been noticed that autolysis proceeds furthest when the range of pH is between 5 and 6. It is thus evident that autolysis is more rapid and complete when both types of enzymes work simultaneously. The author considers that the assumption of the presence of hypothetical agents as "pro-enzymes," "activators" or "anti-enzymes" is unnecessary in explaining variations in autolytic processes if consideration is given to the effects of the presence of both peptic and tryptic enzymes and to the influence of the concentration of hydrogen ion or acidity of the medium. It does not yet seem possible to predict how the acidity of any particular material will change during autolysis, as the estimation of the amount of buffer-matter cannot yet be made accurately.

(188) Purins of the Dalmatian Hound.

H. G. Wells confirms the observation of Benedict that the Dalmatian coach hound excretes large amounts of uric acid, even on a diet free from purins (*Journ. Biol. Chemistry*, August, 1918). This peculiarity in the purin-metabolism of a single species of dogs is remarkable, since the only other mammals known to excrete considerable amounts of uric acid are man and the anthropoid apes. The Dalmatian coach hound has, however, a different type of metabolism from that of man and the anthropoid apes, since it excretes allantoin as well as uric acid in quantity. This discovery is of value, in that it makes it possible to utilize a laboratory animal excreting uric acid under conditions somewhat resembling those obtaining in the human subject. The author found that a female Dalmatian

dog weighing 13.5 kilos excreted 0.037 gm. uric acid per kilo of body weight during each day. This dog was killed and a number of experiments made to ascertain what enzymes were present in certain of the organs. Liver pulp was mixed with a weighed amount of uric acid and incubated for 24 hours in the presence of a stream of air. No uric acid could be isolated, so that it was concluded that uricase was present. When liver pulp was mixed with xanthine, no appreciable formation of uric acid took place in 24 hours, so that it was concluded that xantho-oxidase was absent from the liver of this species of dog. The spleen did not appear capable of changing xanthin to uric acid. The kidney possessed no uricolytic power. The liver exhibited the presence of guanase and adenase ferments. The author concludes that the animal possessed uricase in the liver, but not in the kidney, that the constant excretion of uric acid did not depend on the absence of uricase from the tissues, and that xantho-oxidase was absent from the liver and spleen.

(189) A New Colourimeter.

J. C. Bock and S. R. Benedict describe a new form of colourimeter (*Journ. Biol. Chemistry*, August, 1918). They point out the phenomenal increase in the number of colourimetric estimations applicable to biological chemistry. The Duboscq colourimeter has served the needs of most investigators, but the expense of this instrument has rendered it necessary to have other forms of apparatus. In the new instrument the costly prisms, which are difficult to obtain for the Duboscq instrument, are replaced by mirrors. The objection that the use of mirrors involves too great loss of light, is met by employing only a single reflection and very thin mirrors. First-surface mirrors are too highly priced, so that the inventors have used silvered microscopic cover-slips. As the standard solutions are used always at a fixed height the movable plunger for the standard solution is omitted. As the readings rarely exceed 25 mm., the length of movement is restricted to 30 mm. in the movable cup. Suitable diagrams and directions give the features of construction.

(190) Estimation of Hæmic Iron.

L. Berman describes a rapid method of estimating the quantity of iron present in small quantities of blood (*Journ. Biol. Chemistry*, August, 1918). The iron, which is held in combination with fluid blood, is split off by the action of concentrated hydrobromic acid. The iron is oxidized to the ferric state, and the organic matter is destroyed with potassium permanganate. The resulting solution is mixed with a solution of ammonium sulpho-cyanide in water and acetone. Its colour is compared in a suitable instrument with a standard solution of iron treated in a similar manner. The method occupies 10 or 15 minutes for each determination. A calibrated pipette is used to collect 0.04 c.c.m. blood from a drop obtained in the usual way. This is treated in a small

tube with hydrochloric acid, solution of potassium permanganate and water. After boiling for two minutes in a water bath, 0.1 c.c.m. hydrobromic acid is added. The liquid is filtered into a narrow graduated vessel, to which the solution of sulpho-cyanide of ammonium and acetone are added. The standard is made similarly at the same time. After standing five minutes the liquids are compared in a colourimeter. A set of experiments has been completed to test the reliability of the method.

(191) Citric Acid in Milk.

H. H. Sommer and E. B. Hart have estimated the amount of citric acid in cow's milk, and have examined the effect of heat upon the amount present in milk (*Journ. Biol. Chemistry*, August, 1918). Some investigators have stated that boiling milk decreases the amount of citric acid, and that the use of such boiled milk occasions scurvy or Barlow's disease in infants. The authors used the method of Beau for the estimation of citric acid in milk, in which the citric acid is oxidized to acetone dicarboxylic acid after precipitation of the proteins. The acetone dicarboxylic acid is precipitated with mercury. After filtration the mercury in the precipitate is estimated volumetrically. To satisfy their credulity they isolated citric acid from milk and obtained 5 gm. pure crystals from 10 litres of milk. The crystals were identified as those of citric acid by the Sabanin-Laskowski reaction with ammonia, by the Denigès test with mercuric sulphate, by their titration with alkali, and by conversion to barium citrate. The authors observed no loss of citric acid after heating milk for one hour in an autoclave under one atmosphere pressure. The amount found was about 2 gm. per litre. Some experiments demonstrated that the citric acid remains in solution after heating and is not converted into insoluble calcium citrate.

(192) Feeding in Hyperemesis Gravidarum.

Charles S. Bacon is of opinion that the dieting of the patient is the most important factor in the excessive vomiting of pregnancy (*Journ. Amer. Med. Association*, June 8, 1918). He considers that nothing should be given at first by the mouth. For parenteral feeding he employs the subcutaneous, the intravenous and the rectal paths. By the subcutaneous path water, inorganic salts, glucose, soluble vitamins and sedatives are given. All substances that may be administered subcutaneously, can be given intravenously. The author, however, prefers rectal feeding. He administers vitamins from the pancreas, alcohol, calcium chloride and glucose. Each enema weighs about 400 gms., and has an energy value of about 550 calories per litre. He gives a litre and a half of the solution each day in the form of four enemata. Marked improvement in the condition of the patient is noticed in seventy-two hours. The feeding is usually continued to the sixteenth or eighteenth weeks of pregnancy. Oral feeding should be slowly introduced.

British Medical Association News.

MEDICO-POLITICAL

At a meeting of the Victorian Branch, held on November 13, 1918, it was resolved that the fee for examination for life insurance and report on a short form be 10s. 6d.

At a same meeting the report of the Federal Committee, dealing with the Medical Officers' Relief Fund, was considered and adopted.

A meeting of the Victorian Branch was held on November 20, 1918. There was a very large attendance. It was resolved that a member be expelled "on the ground that his conduct is detrimental to the honour and interests of the members." There was one dissident voice, while a few members refrained from voting.

At a meeting of the Council of the New South Wales Branch, held on November 21, 1918, it was resolved, in connexion with the possible outbreak of influenza in the State:—

That the fee for the administration of vaccine should not be in excess of the ordinary fees in private practice.

That when the vaccination is carried out in mass the fee shall be 5s. per vaccination.

We are requested to point out that the second resolution was inadvertently omitted from the memorandum issued to the members of the New South Wales Branch, with the notice of the meeting to be held on November 29, 1918.

The Council of the New South Wales Branch, after consultation with the Director-General of Public Health and other officers of the Department, issued the following statement for the information of the public.

(i.) The measures so far taken for preventing the introduction of the disease into this State have been eminently successful.

(ii.) That measures have been elaborated to control and combat the disease, should it effect an entry into the State.

(iii.) That the British Medical Association (New South Wales Branch) as a body is in cordial co-operation with the health authorities of the State in this matter.

(iv.) That the wearing of suitable facial masks is calculated to afford material protection to those exposed to infection.

(v.) That there are grounds for believing that protective inoculation, though not of the same value or nature as vaccination against small pox, is a procedure that may be of value in diminishing the liability to grave complications.

The following have been elected members of the New South Wales Branch of the British Medical Association:—

Dr. Stanley George Whitfield ("Kelburn Hall," Elizabeth Bay).

Dr. James Samuel Frederick Barnet (Eltham Avenue, Darling Point).

Dr. Campbell Roy Campling (Denman Avenue, Haberfield).

Dr. Patrick Leo Alphonsus O'Halloran (Newcastle Hospital).

Dr. Eugene Augustine Rogers (Cooper Street, Strathfield).

Dr. A. P. Crawford (Brisbane Hospital, Brisbane).

THE RATTAN COMMISSION.

The Honourable N. K. Ewing, K.C., acting as Royal Commissioner appointed to enquire into the question whether the charges made by the Tasmanian Branch of the British Medical Association concerning the document presented by Victor Richard Rattan to the Medical Council in 1907, for the purpose of obtaining registration as a legally qualified medical practitioner, were justified and true in fact, held the first session of the Commission on November 16, 1918. It is remarkable that in the Royal Commission notice which appears in the *Government Gazette* (No. 7814, of November 12, 1918) there is a striking inaccuracy of description. There is no

such body as the British Medical Association of Tasmania. It is obvious that what is meant is the Tasmanian Branch of the British Medical Association, a body recognized in the year 1911 as a Branch of the British Medical Association, a company (not for profit) registered under the *Companies Act*. It is unfortunate that the advisers of His Excellency should be so careless concerning a matter of description.

The Medical Council was represented by Mr. F. Lodge, while Victor Richard Rattan was represented by Mr. W. M. Hodgman.

At the commencement of the proceedings Mr. Hodgman enquired whether Mr. Lodge was representing the Tasmanian Branch of the British Medical Association (again the description was inaccurate). The Commissioner stated that it was manifest that Mr. Lodge represented the Honorary Secretary of the Tasmanian Branch, but Mr. Lodge explained that he did not represent either the Honorary Secretary or the Tasmanian Branch of the British Medical Association. That body had nothing to do with the enquiry. He represented the Medical Council, a statutory body. The Commissioner admitted that he had not appreciated the difference before. Mr. Lodge further explained that the Medical Council had the duty of keeping a correct register of legally qualified medical practitioners. Early in 1918 the question was raised whether the registration of Mr. Rattan was regular. Nothing was done until September, when Dr. Brettingham Moore, the Honorary Secretary of the Tasmanian Branch of the British Medical Association, addressed the following letter to the President and members of the Medical Council:—

My Council desires to bring under your notice certain documents which have been gathered by them with reference to the qualifications as a medical practitioner of Dr. Victor Richard Rattan, Surgeon-Superintendent of the Hobart General Hospital. Some of these documents were produced in the House of Assembly by Mr. Whitsitt on the 11th instant, and I am enclosing for your perusal a copy of the debate in the House. My Council would call your attention to the *Gazette* notifying the registration of Dr. Rattan as a legally qualified practitioner. This notice is contained in the *Gazette* of May 28, 1907, and his degree is there given as "M.D., Harvey College, Chicago, Illinois, U.S.A., 1907." The year the degree was conferred is very important, in view of the information contained in the document forwarded herewith.

The documents enclosed were:—

(1) A letter from the Secretary of the American Medical Association, dated June 15, 1917, in which it was stated that the Harvey Medical College became extinct in 1905, that it was a night school, which could not be rated higher than Class "C," and that it would require 12 or 14 years to furnish the equivalent to the course given in a recognized medical college.

(2) A letter from the Secretary of the American Medical Association, dated September 7, 1917, in which he stated that he had written to the Secretary of State regarding the final disposition of the charter of the Harvey College.

(3) A further letter from the Secretary of the American Medical Association, dated October 9, 1917, which contained a copy of the reply received by him from the Secretary of State of Illinois, saying that the charter of the Harvey College was cancelled on July 1, 1902.

(4) A certificate declared before a public notary by the Secretary of the Council on Medical Education of the American Medical Association, certifying to a resolution passed by the Harvey Jenner Medical University, and a notice to students to sign for the year 1905-06 at the Jenner Medical College.

(5) A list of the medical colleges of the United States and of foreign countries, which, on the first page, showed that Harvey College was extinct, and that Jenner College was a third-class college.

From a perusal of the above documents, it appears clear that Harvey College was extinct in 1905, after having lost its charter in 1902. Dr. Rattan's degree is dated Harvey College, 1907. My Council think it could hardly be contended that an extinct college could confer a degree, and as neither the Honourable the Chief Secretary nor Dr. Rattan has cleared up or attempted to clear up this discrepancy in dates, my Council think it

is only right, in the interests of the profession, that an explanation should be called for from Dr. Rattan.

On the receipt of this letter the Council met and decided to call on Mr. Rattan for an explanation, since, if his degree was not correct, his name ought not to be retained on the Register. The Secretary of the Council therefore wrote to Mr. Rattan. The Commissioner refused to admit the letter to be read at that juncture. Continuing, Mr. Lodge stated that the reply to the letter from the Council asking for an explanation was that Mr. Rattan forwarded the copy of a cablegram received from America, asserting that the Harvey College existed in 1907. The American official records, however, showed that the Harvey College was not in existence in 1907. In reply to the Commissioner, Mr. Lodge pointed out that the Council had a communication from an authority, while Rattan's communication was merely from an American source. Beyond that the Council had had no explanation from Mr. Rattan, although he had been invited to attend a meeting and to produce his diploma, which he declined to do. The Medical Council was therefore compelled to take other action, when the Government interposed and a Royal Commission was set up. The President of the Medical Council assented to this course, and the members confirmed his action. The Commissioner refused to allow the question of the scope of the enquiry to be discussed. During the discussion on this point it was mentioned by the Commissioner that the Tasmanian Branch of the British Medical Association did not appear to support the charges. Mr. Hodgman attempted to show that Mr. Lodge represented the Tasmanian Branch as well as the Medical Council, since the majority of the members of the latter body were also members of the British Medical Association. Mr. Lodge explained that the Tasmanian Branch was not supporting the charges, for reasons that had been communicated to the Premier, but the Commissioner was indifferent to reasons. The Medical Council had initiated proceedings as soon as they could. Their powers were suspended for the present, but that did not put an end to the duty which still rested on them of saying whether the Register was correct or not.

On November 18, 1918, Dr. E. J. Crouch, Secretary of the Medical Council, gave evidence. He stated that a special meeting of the Council had been held on September 17, 1918, to consider a letter from the Honorary Secretary of the Tasmanian Branch of the British Medical Association with regard to the diploma of Mr. Rattan. At that meeting he was instructed to write to Mr. Rattan to ask him to supply an account of his professional diploma and how it was obtained. On September 24, Mr. Hodgman inspected the documents from the American Medical Association on behalf of Mr. Rattan. Mr. Lodge informed the Commissioner that on September 27 he wrote to Mr. Rattan, asking for a speedy reply, and three days later Mr. Hodgman replied evasively. Mr. Lodge then asked Mr. Rattan to show how he obtained his diploma in 1907, and for what period he proceeded with his studies. On October 3 Mr. Hodgman forwarded to Mr. Lodge a copy of a cablegram which had been received from Chicago, asserting that the Harvey College was in existence in 1907. A cablegram had previously been sent by the President of the Medical Council to the Secretary of the American Medical Association, asking for the date when Mr. Rattan joined the Harvey College. A reply was received on October 2, to the effect that Rattan was not recorded as a student or graduate of the Harvey College.

Dr. Crouch stated that the letter of September 13, 1918, from the Tasmanian Branch was the only complaint they had received concerning Mr. Rattan. There were nine members of the Medical Council, and of this number three were not members of the British Medical Association. He had resigned his membership two or three months before. In reply to Mr. Hodgman, Dr. Crouch stated that he knew nothing of the charges until the correspondence was placed on the table. Mr. Lodge suggested that it was the duty of the Medical Council to see that the Register was regular, and that Mr. Rattan should have complied with the Council's request. The Commissioner interposed with the remark that Rattan had taken up the position that, whatever his qualifications were, he was on the Register, and that Parliament had passed an Act that he was duly registered. He might say to the Medical Council: "Mind your own business." Mr. Lodge stated that that was done on the supposition that a genuine diploma was in existence. The position would be altered if there was not a real diploma. The Commissioner

assented. He gathered that up to the present the Medical Council had made no charge of fraud. All they asked him to do was to attend a meeting and have his status ascertained.

Dr. Crouch knew nothing about the cablegram asking for the date of Rattan's entry into the Harvey College. He knew nothing as to whether this cablegram referred to a college that had lost its charter in 1907. He had seen the letter from the Tasmanian Branch at the meeting of the Medical Council, but he did not think that the correspondence had come through his hands. On October 4 the Council determined to ask Mr. Rattan to attend a meeting, and, if he did not do so, to take immediate action. That might mean that they would place the matter into the hands of their solicitor, but he recognized that it might also mean that they would proceed to remove his name from the Register. In reply to the Commissioner, Dr. Crouch stated that he first got information which led him to believe that the Harvey College was not in existence in 1907 on September 17, at the meeting of the Council. The Commissioner suggested that the cablegram was a complete contradiction of this information. He asked witness whether he was aware that the Commercial Bank had received a reply from America to the effect that the college did exist in 1907. Dr. Crouch said that he may have known it, since the correspondence of the President would come to him. He certainly did not know the authority for this statement. The one cablegram might be official and the other unofficial. He had taken no steps to find out whether the cablegram was true or not. He felt sure that the Tasmanian Branch would do so. The Commissioner said that he would like to know from Dr. Scott, the President of the Medical Council, whether any steps had been taken to ascertain whether or not the Harvey College was in existence in 1907. Mr. Lodge replied that no steps had been taken, because the Government had decided to appoint a Royal Commission. The Medical Council held that there was no occasion to go on with the enquiry; otherwise, their first duty would have been to test the accuracy of the cablegram. The Commissioner expressed the opinion that, unless there had been still further fraud, apparently the College did exist in 1907, but Mr. Lodge claimed that it was apparent that it did not exist at that date. Mr. Hodgman maintained that the Medical Council had had ample time to test the accuracy of the cablegram before the Royal Commission was thought of. Mr. Lodge pointed out that the copy of the cablegram reached the Medical Council on October 3, and on the following day the Government proposed to set up a Royal Commission. He denied Mr. Hodgman's contention that the Council refused to accept the proposal.

The Commissioner announced that, notwithstanding the fact that he had received a notification from the Tasmanian Branch of the British Medical Association, to the effect that they did not propose to attend the enquiry, he would summon them, in order to ascertain whether they were justified in the action they had taken.

Mr. Lodge produced a volume of the official American publication for 1906, issued by the Board of Trustees. This publication contained a list of medical colleges of the United States. Among the unclassified colleges in the State of Illinois there appeared an entry: "Harvey Medical College, extinct." He also produced the 1907 publication. In this the name of the Harvey Medical College did not appear, though the entry of the Jenner College, which had previously been associated with the Harvey College, was given. The Commissioner announced that he would direct a cablegram to the Attorney-General of the State of Illinois to the following effect:—

Please ascertain from State Law Department whether Harvey Medical College charter existed on March 8, 1907, and was its charter on this date in existence, and whether Victor Richard Rattan became a Doctor of Medicine of that College. Cable reply for my information, as a Royal Commission holding an enquiry. Name cost and Attorney-General here will cable it.

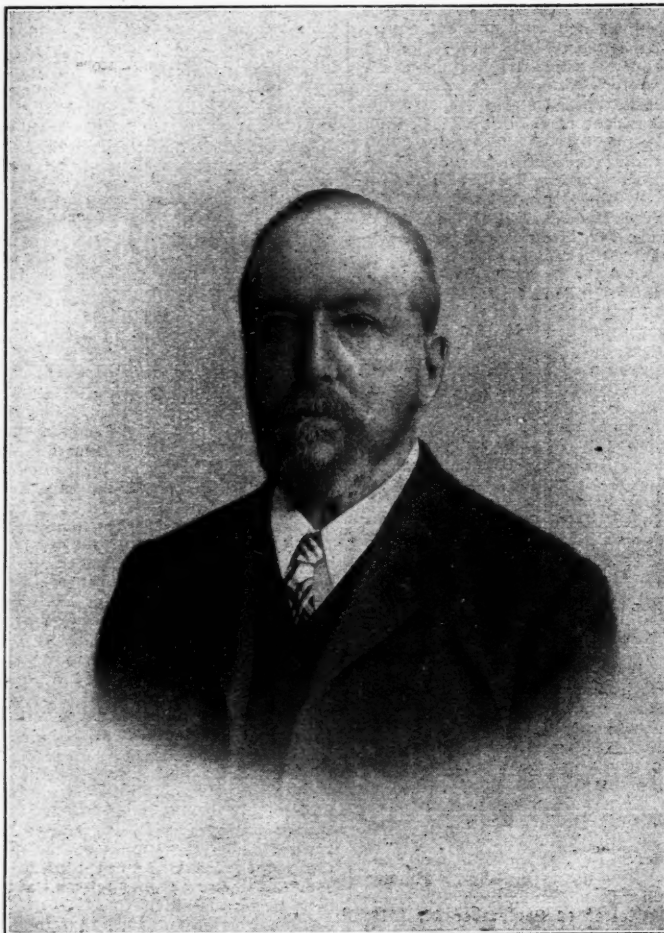
The Commissioner, having read the wording of Rattan's diploma, remarked that, if it were a forgery, it was a fairly comprehensive one.

After an interval, Dr. E. Brettingham Moore, the Honorary Secretary of the Tasmanian Branch of the British Medical Association was called. He was asked whether he had seen a copy of a cablegram received through the Commercial Bank, stating that the Harvey College was in existence in

1907. He replied that he had not seen the copy, but the President had, so he had heard, received one. He did not know whether it was official or not. The Commissioner asked whether his Council had taken any steps to ascertain whether the cablegram was accurate or not. Dr. Brettingham Moore stated that they had another cablegram, which contradicted it. They did not pay any attention to it. They were satisfied when they heard that a cablegram had been received in reply to one sent by the Medical Council that the Harvey College was not in existence in 1907. The Council accepted the official cablegram. The statements concerning Rattan were made before any cablegrams had been received. He still persisted in these statements, because they had the documents and believed them to be true. The Commissioner pointed out that they were charging Rattan with false pretences. Witness replied that if the documents were true, no other thought could come into their minds. He added that they had official information to the effect that Rattan's name was not on the register of the college, and he held that that was more material than whether the college was in existence in 1907. Moreover, the official publication showed that the college was extinct. On the strength of the documents they asserted that Rattan had not been registered. His Council asked for a complete enquiry. Mr. Hodgman asked whether the cablegram sent by the Medical Council referred to an institution that had ceased to exist in 1902, to which witness assented. Mr. Hodgman continued by suggesting that when the reply came that Mr. Rattan was not a graduate of the 1902 institution, whether they still asserted their charges, in view of the further cablegram. Witness replied that if the college were extinct, there was sufficient evidence. Mr. Hodgman put it that they had the other cablegram that it was not extinct. Witness replied that they had not then seen that cablegram.

He was further cross-questioned concerning the names of the members of the Medical Council. Continuing, he stated that his Council had some information ten months before they acted on it, because they were adding bit by bit to it and wanted to get a good case before they pushed it. They took no steps for ten months because they wanted further information.

The enquiry was then adjourned pending the receipt of the reply to the cablegram sent to America by the Commissioner.



THE LATE DR. CORBIN.

Through the courtesy of the friends of the late Dr. Thomas Wilson Corbin, we are now able to reproduce a portrait of our lamented and highly esteemed colleague.

MILITARY APPOINTMENTS.

The following notices appear in the *Commonwealth of Australia Gazette*, No. 182, of November 21, 1918:—

Australian Imperial Force.

The following appointments have been terminated:—
First Military District.

Lieutenant-Colonel H. H. B. Follitt. Dated 21st October 1918.

Major H. V. Foxton. Dated 2nd November, 1918.

Third Military District.

Captain S. M. Ware. Dated 6th November, 1918.

Australian Naval and Military Expeditionary Force.

The notice regarding the termination of the appointment of Captain J. G. Skeet, Australian Naval and Military Expeditionary Force, referred to in Executive Minute No. 678/1918, promulgated on page 1893 of *Commonwealth of Australia Gazette*, No. 152, is cancelled.

Correspondence.

TARSECTOMY FOR TRACHOMA.

Sir,—In your issue of August 10, 1918, in the report of the Ophthalmological Society of New South Wales, there are several statements which, I think, ought not to go unchallenged.

Dr. Shepherd is reported to have said, in connexion with Heisrath's tarsectomy for trachoma, that "to obtain the cosmetic result, it was necessary to make the incision parallel to the lid margin throughout its entire length." I have found that such a parallel incision destroys the natural convexity; and that, if this is to be preserved, one must taper the residual piece of marginal cartilage at each end by making the incision nearer to the

lid margin at the extremities than in the middle. This, however, is a minor criticism.

He is also reported to have said "It was a very good operation in active trachoma," though he rightly modifies this by excluding cases where there is active disease in the retro-tarsal fold. Experience has taught me to be very chary of operation in any but late stages of the disease, where there is deformity and roughness of the tarsus, and often corneal irritation depending thereon.

He said, further, that "it was an excellent operation when there was acute pannus," in which case, at the same time, he did a peritomy. An acute pannus means an acute infec-

tion of a chronic condition. This is probably a Koch-Weeks infection, or may be associated with small ulcers. I should deprecate any operation while the pannus was acute, a peritomy no less than a tarsectomy. Treatment with *arg. nit.* and atropine, for several weeks if necessary, should precede any operative interference. I have seen very violent reaction and severe ulceration follow a peritomy done too early. In the quiescent stage of pannus I think that both the operations named play a valuable part.

As I appreciate Dr. Shepherd's contribution to the technique of tarsectomy very much—his clamp and method of suture—I hope he will not take these remarks as captious. They are merely what I should have said, had I been present.

Dr. D'Ombain, too, is reported to have said that "opaque (retinal) nerve fibres had never been recorded on more than one side of the disc." In my experience they occur quite as often on two sides of the disc as on one, generally at opposite poles. This arrangement is figured in Fuchs' textbook, and, if my memory serves me, in most atlases. And, when one considers the pathology of the condition—it has no connexion with the foetal cleft, which is closed before birth—there is no anatomical reason why they should be confined to one side.

Yours, etc.,

E. TEMPLE SMITH,

Major, A.A.M.C.

No. 14 Australian General Hospital, Egypt,
October 4, 1918.

THE HOSPITAL OF THE FUTURE IN AUSTRALIA.

Sir,—I am glad to have the opportunity of welcoming back by old friend Colonel Hayward, who has done such good work for Australia and the Empire.

My statement to which he takes exception that: "At the Eastern Military Hospital, Cambridge, the exposure led to considerable suffering and discomfort to the patients," is based upon a letter from a sister in charge of one of the wards in that hospital.

Evidently the nurses, whom Colonel Hayward interrogated, held similar views regarding their own "discomfort and suffering" while working in open wards. Can nurses do their best work under such disadvantageous circumstances?

I have seen or read nothing to shake my belief that the best treatment is carried out in airy, conveniently planned wards, capable of being warmed in winter, opening on the north side into wide verandahs, to which to patients are wheeled, bed and all, whenever it seems desirable.

Yours, etc.,

(Undated.)

RALPH WORRALL.

PROPHYLACTIC USE OF RESPIRATORS.

Sir,—The use of a respirator as a safeguard against infection with the germs producing "Spanish Influenza" seems to be based on some conception that the virus may be inhaled with the breath. It was at one time supposed that the contagion of many infectious diseases was wafted through the atmosphere, but more knowledge of the nature of the infecting agent and of the modes of its transmission created much scepticism in regard to air-borne infection. When the infective microbes are lodged in the nose, mouth and throat, the buccal and nasal secretions are more or less infested with the germs. These secretions contaminate the lips, and are smeared on the face, cheeks and hands. They are swept by coughing, sneezing, or violent speech to the clothes of the patient, to surrounding objects, and to the bodies of those who come sufficiently close to the sufferer. They are picked up by the fork and spoon, and transferred to plates and food. They pollute cups, glasses and drinking vessels. They taint the towels used in washing the face or body. The infected secretion conveys the disease and not the air. Every drop, however small, of nasal mucus or of saliva can spread the infection further afield.

Infection is brought about by the transference of some of the infective material from the patient to the mouth or nose of another person. This may be done by the hands,

by some towel or table requisite, or in any other less direct manner. The essential steps of the infective process will be contact of some object with the infected secretion, and conveyance of a portion of the secretion by that object to the nose or mouth of the person contracting the disease.

When the germs are distributed by the dissemination of the nasal and buccal secretions, it will only occasionally happen that the disease is spread by direct bespattering of the nose and mouth with the virus. More often the germs reach the clothes or person of healthy persons who, later, transport the infection to their own air passages. A respirator will lessen direct infection of the lips and mouth, but will be valueless against the others paths of infection. When the microbes are scattered over the respirator, they will also be spread over the neighbouring clothes and body, ready to be transmitted to the air passages. It will thus be evident that respirators have little use in preventing infection.

An epidemic of such a disease as "Spanish Influenza" can be controlled by isolating those who become diseased, by prohibiting the assembly of persons in public halls, meeting places and restaurants, and by restricting the use of trains, trams and ferries. The individual who avoids his fellows as much as possible, runs least risk.

Yours, etc.,

HENRY G. CHAPMAN.

University of Sydney,

November 25, 1918.

Proceedings of the Australian Medical Boards.

NEW SOUTH WALES.

The following have been registered under the provisions of the *Medical Act, 1912 and 1915*, as duly qualified medical practitioners:—

Barlow, Charles Dight, M.B., Mast. Surg., 1918, Univ., Sydney.

Elliott, Edmund Alfred, M.B., Mast. Surg., 1918, Univ., Sydney.

Hunter, Hugh, M.B., 1918, Univ., Sydney.

Luker, Alexander MacCredie, M.B., Mast. Surg., 1918, Univ., Sydney.

Melkle, Eric, M.B., Mast. Surg., 1918, Univ., Sydney.

Milgrove, Edward Leslie, M.B., Mast. Surg., 1918, Univ., Sydney.

Whitfield, Stanley George, M.B., Mast. Surg., 1918, Univ., Sydney.

Middleton, Clarence James, Lic. R. Coll. Phys., Edin., 1917; Lic. R. Coll. Surg., Edin., 1917; L.F.P.S., Glasg., 1917.

QUEENSLAND.

The following have been registered under the provisions of the *Medical Act, 1867*, as duly qualified medical practitioners:—

Calov, Walter Leopold, Toowoomba, M.B., Ch.M., Univ., Syd., 1918.

Crawford, Andrew Pimkerton, Brisbane Hospital, M.B., Ch.M., Univ., Sydney, 1918.

Dillon, Lurline Winifred, Brisbane, M.B., Ch.M., Univ., Syd., 1918.

Doyle, Gerald Vincent Francis, Brisbane Hospital, M.B., Ch.B., Univ., Melb., 1916.

Gall, Leslie Wohlgenuth, Brisbane Hospital, M.B., Ch.M., Univ., Syd., 1918.

Hogg, Joseph Ballantine, Brisbane Military Hospital, M.B., Univer., Syd., 1918.

O'Flynn, Jerome, Gin Gin, M.B., Ch.B., N.U.I., 1913.

SOUTH AUSTRALIA.

The following have been registered under the provisions of the *Medical Act, 1880*, as duly qualified medical practitioners:—

Hogg, Robert Welton, M.B., B.S., Melb., 1915.

Plotz, Oscar Arnold, M.B., B.S., Ade., 1916.

Books Received.

- A MANUAL OF PHYSIOLOGY, by G. N. Stewart, M.A., D.Sc., M.D., D.P.H.; Eighth Edition, 1918. London: Baillière, Tindall & Cox; Demy 8vo., pp. 1,245, with one coloured plate and 492 other illustrations. Price, 21s. net.
- THE AUSTRALIAN ARMY MEDICAL CORPS IN EGYPT, by Lieutenant-Colonel James W. Barrett, C.M.G., M.D., M.S., F.R.C.S., and Lieutenant P. E. Deane, A.A.M.C.; 1917. London: H. K. Lewis & Co., Ltd.; Demy 8vo., pp. 250, illustrated.
- DIGGER SMITH, by C. J. Dennis, illustrated by Hal Gye; 1918. Sydney: Angus & Robertson, Ltd.; Crown 8vo., pp. 113. Price, 4s. 6d.
- TALES OF SNUGGLEPOT AND CUDDLEPIE, by May Gibbs, in pictures and words; 1918. Sydney: Angus & Robertson, Ltd.; Crown Quarto, pp. 87. Price, 3s.

Medical Appointments.

Dr. Edward H. Fyfe (B.M.A.) has been appointed a Certifying Medical Practitioner at Malvern, Victoria, under the provisions of the *Workers' Compensation Act, 1915*.

Dr. R. S. Rogers (B.M.A.) is one of the nominees of His Excellency the Governor of South Australia for the Board of Governors of the Public Library, Museum and Art Gallery of South Australia. The University of Adelaide has elected Professor Sir Edward Stirling, C.M.G., F.R.S., and Professor G. C. Henderson members of the same Board.

Medical Appointments Vacant, etc.

For announcements of medical appointments vacant, assistants, locum tenentes sought, etc., see "Advertiser," page xiii.

In future, no advertisements inviting applications from medical practitioners for positions in public institutions will be accepted unless the appointment is limited to medical practitioners who are ineligible for military service, or who have returned from military service. The term "ineligible for military service" is used to signify practitioners who are above military age, those who have offered their services and have not been accepted by the military authorities, or those who, for valid reasons, are incapable of applying for a commission in the Australian Army Medical Corps.

Red Cross Sanatorium, Wentworth Falls, N.S.W., Assistant Medical Superintendent.

Gladstone Hospital, Queensland, Medical Officer.

Medical Appointments.

IMPORTANT NOTICE

Medical practitioners are requested not to apply for any appointment referred to in the following table, without having first communicated with the Honorary Secretary of the Branch named in the first column, or with the Medical Secretary of the British Medical Association, 429 Strand, London, W.C.

Branch.	APPOINTMENTS.
VICTORIA. (Hon. Sec., Medical Society Hall, East Melbourne.)	All Friendly Society Lodges, Institutes, Medical Dispensaries and other contract practice. Australian Prudential Association Proprietary, Limited. National Provident Association. Mutual National Provident Club.
QUEENSLAND. (Hon. Sec., B.M.A. Building, Adelaide Street, Brisbane.)	Australian Natives' Association. Brisbane United Friendly Society Institute. Rockhampton Associated Friendly Societies. Cloncurry Hospital.

Branch.	APPOINTMENTS.
SOUTH AUSTRALIA. (Hon. Sec., 3 North Terrace, Adelaide.)	Contract Practice Appointments in South Australia. Contract Practice, Appointments at Renmark.
WESTERN AUSTRALIA. (Hon. Sec., Health Department, Perth.)	All Contract Practice Appointments in Western Australia.
NEW SOUTH WALES. (Hon. Sec., 30-34 Elizabeth Street, Sydney.)	Australian Natives' Association. Balmaln United F.S. Dispensary. Canterbury United F.S. Dispensary. Leichhardt and Petersham Dispensary. M.U. Oddfellows' Med. Inst., Elizabeth Street, Sydney. Marrickville United F.S. Dispensary. N.S.W. Ambulance and Transport Brigade. North Sydney United F.S. People's Prudential Benefit Society. Phoenix Mutual Provident Society. F.S. Lodges at Casino. F.S. Lodges at Lithgow. F.S. Lodges at Parramatta, Auburn and Lidcombe. Newcastle Collieries — Killingworth, Seaham Nos. 1 and 2, West Wallsend.
TASMANIA. (Hon. Sec., Macquarie Street, Hobart.)	Medical Officers in all State-aided Hospitals in Tasmania.
NEW ZEALAND: WELLINGTON DIVISION. (Hon. Sec., Wellington.)	Friendly Society Lodges, Wellington, N.Z.

Diary for the Month.

- Dec. 3.—N.S.W. Branch, B.M.A., Ethics Committee.
Dec. 3.—Vic. Branch, B.M.A., Ballot Papers for Election of Office-bearers Returned.
Dec. 4.—Vic Branch, B.M.A., Annual; Election of Office-bearers.
Dec. 6.—Q. Branch, B.M.A.
Dec. 10.—Tas. Branch, B.M.A., Council and Branch.
Dec. 10.—N.S.W. Branch, B.M.A., Executive and Finance Committee.
Dec. 11.—South Sydney Med. Assoc. (N.S.W.).
Dec. 12.—Vic. Branch, B.M.A., Council.
Dec. 13.—S. Aust. Branch, B.M.A., Council.
Dec. 13.—N.S.W. Branch, B.M.A.
Dec. 17.—N.S.W. Branch, B.M.A., Medical Politics Committee; Organization and Science Committee.
Dec. 19.—City Medical Assoc. (Sydney, N.S.W.).
Dec. 20.—Q. Branch, B.M.A., Council.
Dec. 26.—S. Aust. Branch, B.M.A.

EDITORIAL NOTICES.

Manuscripts forwarded to the office of this Journal cannot under any circumstances be returned.

Original articles forwarded for publication are understood to be offered to *The Medical Journal of Australia* alone, unless the contrary be stated. All communications should be addressed to "The Editor," *The Medical Journal of Australia*, B.M.A. Building, 30-34 Elizabeth Street, Sydney, New South Wales.